Unearthing the Buried City

The Janet Translation Project

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2025

This document is part of *Unearthing the Buried City: The Janet Translation Project*, a series of AI-assisted English translations of Pierre Janet's works.

In his seminal 1970 book: *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*, Henri Ellenberger wrote:

> *Thus, Janet's work can be compared to a vast city buried beneath ashes, like Pompeii. The fate of any buried city is uncertain. It may remain buried forever. It may remain concealed while being plundered by marauders. But it may also perhaps be unearthed some day and brought back to life* (p. 409).

This project takes Ellenberger's metaphor seriously — and literally. The goal of this work is to unearth the buried city of Janet's writings and make them accessible to the English-speaking world, where much of his legacy remains obscured or misunderstood.

Pierre Janet was a pioneer of dynamic psychology, psychopathology, hypnosis, and dissociation. His influence on Freud, Jung, and the broader psychotherapeutic tradition is profound, yet the bulk of his original writings remain untranslated or scattered in partial form. These AI-assisted translations aim to fill that gap — provisionally — by making Janet's works readable and searchable in English for the first time.

This is not an academic translation, nor does it claim to replace one. It is a faithful, literal rendering produced with the aid of AI language tools such as Chat GPT and DeepL and lightly edited for clarity. Its purpose is preservation, accessibility, and revival. By bringing these texts to light, I hope to:

- Preserve Janet's contributions in a readable English form
- Spark renewed interest among scholars, clinicians, and students
- Inspire human translators to produce definitive, academically rigorous editions

Parasitic Cyst of the Brain[1]

Accidents of neuropathic appearance. — Sleep attacks, choreic tremor, facial hemispasm. Death. — Results of the autopsy.

By Mr. Pierre Janet
student of the service

Saint-Antoine Hospital. — Service of Dr. Hanot.

Parasitic cysts of the brain are rather rare and difficult to diagnose during life; in this respect, the following observation, which we recorded in the service of our eminent teacher, Dr. Hanot, is not without interest. It concerns a young girl who, by her hereditary and personal antecedents, seemed predisposed to neuropathic accidents. Her illness, at least in the beginning, could have suggested either a hysterical manifestation or chorea. It is true that the symptoms were never clear enough to affirm either of these conditions with certainty, but hesitation was permitted. Moreover, the gravity of the accidents and their fatal outcome soon resolved all doubts. The autopsy enabled us to observe a large tumor located at the extremity of the left temporal lobe, and the histological examination that we were able to carry out, thanks to the help of our friend, Mr. Létienne, intern of the service, demonstrated the parasitic nature of this cerebral cyst.

A girl named M. Camille, aged 14 and a half, was admitted on August 4, 1891, to the service of Dr. Hanot at the Saint-Antoine Hospital, Grisolle ward, bed no. 6.

Hereditary Antecedents

The father died at age 56 during an episode of delirium tremens. He had been an alcoholic for a very long time; his children report that he was drunk every evening and that he was in a state of nearly constant anger and delirium.

The mother, who is still alive, suffers from a dropsy the cause of which we have not been able to verify.

This family had five children, all of whom show notable alterations of the nervous system—hereditary defects.

(1) The eldest daughter suffered for a long time from major hysterical attacks; she no longer has convulsions at present, but she shows major character disturbances: violent, irritable, jealous, constantly spying on her husband, she is continually tormented by ideas of persecution.

(2) A son, currently aged 29, was never able to learn anything; he used to be able to speak, but for several years now he has remained in a nearly complete mutism.

[1] Janet, Pierre. “Kyste parasitaire du cerveau,” *Archives générales de médecine* (1891), II, pp. 464-472.

(3) Another son is, on the contrary, very lively, very restless, very talkative. He has a very unstable and highly irritable temperament, and he is said to have had some minor nervous crises of no great seriousness.

(4) A daughter who is married and has young children in good health displays all the features of the madness of doubt; always sad, always tormented by her obsessive thoughts, she constantly calculates when she will go mad—within the hour, the day, the year, etc.

(5) Finally, the youngest child, Camille, who is the subject of this observation.

Personal Antecedents

Camille was, from early childhood, very strange; she had large, vacant eyes that seemed to stare into the void — one of her sisters told me —; she was very wild, refused to speak, and at first was resistant to all forms of instruction. Quite suddenly, around the age of 9, she completely changed in demeanor, became very cheerful, very excitable, and showed great intellectual liveliness; she very quickly learned everything one wanted to teach her: in a short time, she could speak and write English just as well as French.

At that time, she was sent to join relatives she had in America. She stayed there for two years and was employed in rather tiring work on a farm; she did not complain about it and was considered robust and intelligent.

She menstruated for the first time a few months ago, that is, at the age of 14, without any trouble. Her periods occurred regularly for several months, then disappeared completely at the onset of the symptoms of her final illness.

This young girl felt, as she said, tired and numb, and complained of a continuous headache (beginning of June 1891). A few days later, one evening she began to rave, crying out and speaking of animals and imaginary objects that she saw in front of her. This delirium lasted hardly more than one night and was not accompanied by convulsions. But afterward, the patient seemed to fall asleep little by little and entered into a deep sleep that continued for fifteen days without any interruption. It was impossible to obtain from her a single word, a single sign; at most, from time to time she could be made to swallow a little milk.

As she seemed to be waking up and feeling better, they took advantage of a period of improvement to send her back to France to her parents.

She arrived in Paris last July, and although she seemed at first to be in fairly good health, she relapsed the very next day into a state of torpor and sleep similar to the previous one, but less deep. She remained lying down, eyes usually closed, without convulsions or delirium. When spoken to, she replied with a few words, saying that she had a headache and begging to be left to rest in peace.

A few days later, she presented a new troubling symptom: she would vomit her food as soon as she had swallowed it, and sometimes the vomiting efforts would make her bring up — her sister told us — grayish matter with a fetid odor similar to that of fecal matter. However, these vomitings rather easily disappeared following a remark from her family. She always vomited immediately after eating, as long as she remained lying in bed, but it was enough to make her get up

after her meal, to force her to stand and walk around for a little while after eating, to eliminate the nausea and vomiting.

As her state of torpor and sleep did not change, it was decided to bring her to the hospital, and she was admitted to Saint-Antoine, in the service of Dr. Hanot, on August 4, 1891.

Current State

The examination of this young girl presents no particular difficulties; despite her drowsy condition, she is easily awakened, she gets up or moves and does what is asked of her; finally, she answers questions in a fairly correct and intelligent manner. She is a rather tall girl, who seems well-built, is not too thin, and shows no clear signs of degeneration in her external appearance. The organic functions seem to operate normally; the examination of the chest, the auscultation of the heart reveal no lesion; the urine contains no sugar, no albumin; digestion proceeds well, at least during the first days of her admission to the hospital. The temperature taken in the rectum is 37.8°C, the pulse is 80 beats per minute.

The examination of the nervous functions allows us to make the following remarks, which we will summarize by describing movement, sensitivity, memory, and intellectual operations.

Movements

The patient can perform all the movements asked of her; she moves her arms and picks up objects; she walks well, although she pays no attention to the objects in front of her, and bumps into columns. If guided, the movements of her legs, like those of her arms, are correct. However, the patient complains of pain in her left knee; she says she has felt shooting pains in that area since the beginning of her illness.

The objective examination of the knee as well as the left leg reveals nothing abnormal to us; the movements are easy and can be performed in all directions, the leg resists strongly against forced extension, as well as against flexion. On the contrary, the limbs on the right side, of which the patient makes no complaint, seem to move with more difficulty. The right leg trembles a little while walking and resists weakly to commanded movements. The right arm is clearly weaker than the left; the right hand cannot squeeze the dynamometer beyond degree 12, whereas the left easily reaches 18 to 20. Moreover, the movements of the right arm cannot last long; the arm seems to hang in the air for a moment, then falls again irregularly, the hand cannot remain still for a moment, it suddenly relaxes irregularly, and when one holds her wrist, one feels oscillations and alternations of pressure and release. Finally, the right arm displays true tremors in all voluntary movements; when the patient wants to bring a glass of milk to her lips, she shakes it and spills part of its contents; one morning, in the ward, she even let it fall from her hands. These tremors also show in her writing: the writing is irregular, jerky, and not without some analogy to the writing of choreics.

If we now examine the muscles of the face, we are struck by the evident deviation of the mouth. The left corner of the lips is drawn upward, the left cheek is contracted, and if we ask the patient to stick out her tongue, the tip of the tongue deviates to the left. This deviation is not due to a paralysis of the muscles on the right side, for the patient can, on our request, make the same grimace on the right side. This deviation is clearly due to a spasm of the muscles on the left side. This spasm is not permanent; it shows irregularities, oscillations, and can, from time to time, disappear completely. The movements of the eyes are absolutely normal, and we observed neither strabismus nor nystagmus. We finally note a clear disturbance of the respiratory movements. The patient usually breathes quite well and does not have dyspnea; she breathes deeply when told to. But when she is distracted, when her attention is occupied with something else, she seems at times to stop breathing, then after a moment, breathing resumes with exaggeration only to stop again soon after, when the patient again forgets to breathe (breathing that resembles the Cheyne–Stokes type). We will end the examination of movements by noting that all reflexes in the legs, the pharynx, and the eyes have remained absolutely normal.

The examination of *sensitivity* reveals no clearly defined symptoms; there is no truly anesthetic region. At most, one might note a slight decrease in tactile sensitivity on the right side (40 on the aesthesiometer applied to the lower surface of the wrist compared to 25 on the left side). Muscular sense is intact on both sides, and the patient never forgets the limbs in cataleptic postures. The special senses appear to have retained all their acuity; hearing and vision are normal on both sides, and the visual field is not narrowed.

The patient reports little pain; she complains a bit about her left knee and says she has a headache, but she points to her forehead vaguely and, moreover, does not seem to suffer much.

We carefully examined the state of her *memory*, which seemed important to us. It is certain that the memory of events prior to the first symptoms of the current illness is preserved in a very precise manner. Despite the difficulty of getting this patient to speak—she would fall asleep again at any moment—we questioned her about all the periods of her life during recent years, without noting any gaps in memory. On the contrary, as was easy to predict, she forgets recent events, to which she pays very little attention; thus, she hardly remembers how she was admitted to the hospital, nor with whom she spoke the day before.

Language is preserved in all its forms; she always understands (when her attention has been sufficiently engaged), she speaks, she reads, and she writes; she still remembers the English language she spoke in America.

The most striking fact is the difficulty with attention. She must constantly be shaken for her to listen; she seems to suffer when she tries to think and to speak. As soon as she is left alone, she remains motionless, her eyes most often closed, in a state of complete drowsiness. In this sleep, she says she dreams sometimes, but rarely, and most often she thinks absolutely nothing. Apart from this difficulty—this suffering caused by the effort of thinking—we have observed no delirium, nor any disturbance of the intellectual faculties.

Course of the Illness

About a week after the admission of this patient to the service, her condition worsened in a striking manner. The vomiting, which had disappeared, resumed, and the patient retained no food at all; she visibly grew thinner. Her temperature, which had remained at 38°C, quickly rose to 40°C; the pulse dropped from 80 to 60, and this dissociation between temperature and pulse naturally led us to suspect meningitis. The torpor and drowsiness further increased, and the patient responded only with a few words when shaken out of her stupor. However, we note that the condition of her movements remained the same: the paresis on the right side did not worsen, the facial spasm diminished, and the movements of the eyes remained normal.

A few days later, the patient showed a period of apparent improvement: the temperature dropped to 38.8°C, and the pulse rose to 70. The vomiting ceased, and the patient was able to eat a little; the intellectual torpor was somewhat less pronounced, and the facial deviation disappeared. But this improvement was only apparent; the patient quickly became less and less conscious, began to lose control of her urine and feces in bed. When a piece of food is placed in her mouth, she holds it there indefinitely and forgets to swallow it. However, if she is shaken a little, she swallows without choking and still answers a few questions.

On the morning of the 29th, she had some slight convulsions of the arms and suddenly stopped breathing. As the heart was still beating strongly and her face was becoming cyanotic, artificial respiration was attempted. But all was in vain, and the patient died a short time later.

Autopsy

The autopsy was performed the next day and revealed the presence of a rather large tumor in the anterior extremity of the left temporal lobe.

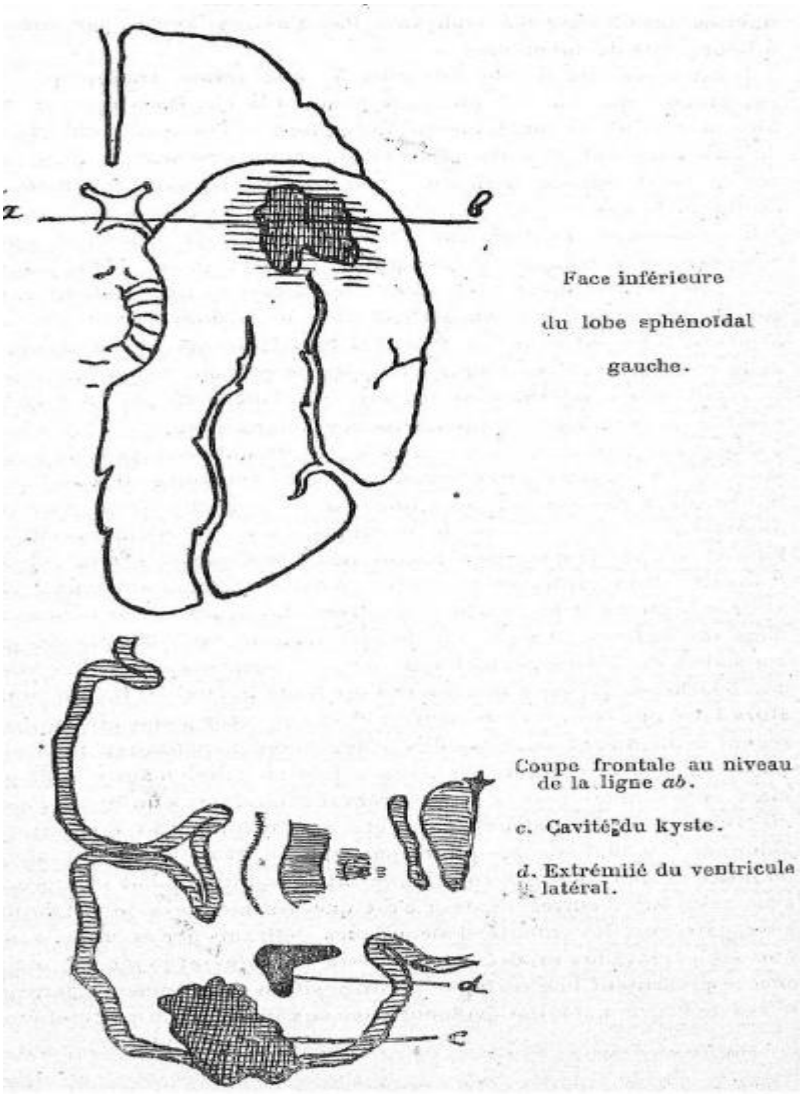
The brain, over the entire surface of the convolutions, is absolutely normal—except at the level of the left temporal lobe; in fact, the lower surface of this lobe shows, near its anterior extremity, two small hollow nodules about the size of a ten-centime coin, formed by softened convolutions. The brain tissue is soft and colored by crystals of hematoin. All around this stain, the gray matter has lost its consistency. Inside this lobe, there is a nearly circular cavity about 3 centimeters in diameter, which extends a bit toward the posterior part of the brain. This cavity is entirely situated in the tip of the sphenoidal lobe, and neither the internal capsule nor the first temporal convolutions are affected.

A membrane lines this cavity and adheres intimately to the surrounding brain tissue; it can only be detached by scraping. This membrane is highly vascularized, pinkish, transparent, and about the thickness of the dura mater. Inside, there is a small quantity of yellowish serous fluid. The inner surface of the cavity presents depressions filled with the same fluid, and one of them contains a thin, white membrane. This membrane is lodged in one of the recesses of the cavity, and when pulled, it appears in the form of a small cyst, half emptied. It contains a

serous fluid, cloudy and of a much darker coloration than the serous fluid of the main cavity.

Examined under the microscope, the softened, dissociated convolutions show fragmented myelin balls, granular bodies, and the hematoin crystals described by Virchow and Gubler. The membrane that floated in the cavity is composed of colorless sheets finely granular and striated; these are interwoven one over another, and the planes of their fibers sometimes intersect in various directions. On this membrane, one sees small refringent corpuscles that still exist in the fluid of the cavity; in no preparation have we seen hydatid hooks; but we do find small corpuscles surrounded by a membrane enclosing a granular protoplasm of a yellowish color (without any preparation artifact). These bodies appear analogous to the eggs of certain helminths. One cannot affirm with certainty the hydatid nature of this cyst, but its parasitic nature can be admitted.

As for the other viscera, they show no trace of morbid alteration other than the congestive lesions commonly found in cases of asphyxia. No other parasitic cysts elsewhere, no tubercles.



Face inférieure du lobe sphénoïdal gauche.

Coupe frontale au niveau de la ligne *ab*.

c. Cavité du kyste.

d. Extrémité du ventricule latéral.

It is rather difficult to relate this anatomical lesion to the symptoms observed during life. The functions dependent on the anterior extremity of the temporal lobe have not yet been well determined, and our observation unfortunately provides no precise indication on this point. One must probably explain the spasm of the face on the same side as the cyst by a meningeal reflex. Can the paresis of the right side be related to a compression at a distance of the internal capsule? As for the dullness and profound torpor of intellectual functions, these are characteristics that belong to quite varied cerebral lesions. It is the same for the vomiting and respiratory disturbances. We are struck by seeing such a considerable cerebral lesion result, during life, in only a small number of clearly defined intellectual changes.

As for the very nature of this cyst, Dr. Hanot believes that it can, without hesitation, be considered a hydatid cyst. It is certainly an old tumor, for the elements found there seem more like signs of mortification than of active life. Must one suppose that this lesion remained dormant for some years? One could perhaps explain the course of this slow cerebral illness, the strange demeanor and intellectual disturbances presented by the patient during childhood, by this lesion. But it seems more plausible to explain the developmental anomalies observed in this child by the hereditary neuropathic burden that so heavily weighs on the entire family. One could then say that this young girl clearly belonged to a family of hereditary degenerates, showing that certain signs appear in the brain tissue as in *locus minoris resistentiae*. Perhaps this neuropathic state contributed to giving the illness a particular character. Our observation would then highlight an interesting fact that agrees with many other studies: namely, that members of the neuropathic family, children of delirious alcoholics for example, are not only more exposed to various nervous afflictions, but also show a certain predisposition to parasitic tumors of the brain, which evolve in them in a particular way.

Pierre Janet